Physician-assisted suicide

Larry R Churchill PhD *Professor and Chair, University of North Carolina School of Medicine, USA*

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Introduction

'Suicide' as a term is only 300 years old, but as a practice it is likely as old as our species. It would be prudent to begin with some of the views of our predecessors. Socrates argued that people should not take their own lives but did allow for exceptional circumstances. Believing he had received a divine sign he chose death over exile when his work in Athens was done. The Stoics, especially the late Stoics, Seneca, Epictetus, Marcus Aurelius, believed that a person always continued to live by his own consent, and this was understood as a part of human freedom. Jewish opposition to this Greek and Roman tradition was expressed by the first century Governor of Galilee, Josephus Flavius, who forbade his troops to commit suicide following a military defeat. The early Christian church, born in a time of Jewish apocalypticism and Platonic dualism, faced the problem of new converts who engaged in reckless self-destructive acts to escape the sins of this world in order to embrace, all the sooner, the bliss of the next. It was in this context that the classical Christian prohibition of suicide was devised by Augustine of Hippo. He interpreted suicide as forbidden under the commandment against killing. He also portrayed the examples of Roman suicide, such as Cato the Younger, as vain and cowardly. It was Augustine who gave definitive expression to the theological trump card on suicide still being played: the belief that this present life is a Providential test of spiritual worthiness[1,2]. Killing oneself is, then, an avoidance of divinely-given responsibility, a refusal to complete the qualifying exam for the afterlife.

Thomas Aquinas added three arguments to the theological prohibition of suicide. He portrayed it as contrary to the charity one owes to oneself, a shirking of the duties one owes to society, and a usurpation of the prerogatives of God[3]. It is largely in opposition to Aquinas, or perhaps some eighteenth century Calvinist who knew Aquinas, that David Hume seemed to direct his arguments. Montaigne is the first in a line of continental dissenters from Christian orthodoxy on suicide, followed notably by Montesquieu and Voltaire. Montesquieu asserted that suicide does not disturb divine Providence any more than other interventions into nature, such as changing the course of a river. Hume developed Montequieu's argument, and those of the Stoics, that if the disposal of human life were left to the Almighty, any action to avoid death would be an infringement on divine sovereignty.

> If I turn aside a stone which is falling on my head I disturb the course of nature and invade the peculiar province of the Almighty by lengthening out my life beyond the period, which, by general laws of matter and motion, he had assigned to it[4] (p 583).

Rather than see suicide in opposition to divine Providence, Hume believed it could well be in accord with it.

> When I fall upon my sword, therefore, I receive my death equally from the hands of the Deity, as if it had proceeded from a lion, a precipice, or a fever[4] (p 584).

Hume rightly observed that, once we begin to interpret actions as expressions of divine will, there is no more reason to exclude suicide than to exclude diseases or accidents. If Providence guides some causes, why not all? Hume reasoned that

> whenever pain and sorrow so far overcome my patience as to make me tired of life, I may conclude, that I am recalled from my station, in the clearest and most express terms[4] (p 585).

Regarding Aquinas' argument that there is a social obligation to continue living, Hume replied:

> A man who retires from life does no harm to society, he only ceases to do good; which, if it is an injury, is of the lowest kind . . . and where my life is a positive burden to society, my withdrawal from it is not only innocent but laudable[4] (p 585).

Assisted Suicide

The orthodoxy about suicide in the late twentieth century is not, however, centred on issues or sin, nobility or freedom, but on psychiatric categories. The psychiatric picture of suicide portrays it as a despairing act, one carried out under a cognitive disability or depression. Suicidal acts are symbolic cries for help. I do not deny the appropriateness of psychiatric interpretation, only the presumption that it is all-encompassing. If either theological or psychiatric categories are thought to exhaust the possibilities for interpreting voluntary death, then questions of physician-assistance are moot. I will proceed, without giving full arguments, under the assumption that suicide remains a reasonable possibility, however exceptional. That is, at least some acts of suicide are neither sins nor signs of illness, and reflect a legitimate human option for how life should end.

If suicide can be made comprehensible, or rational from the patient's perspective, then we must entertain as a serious ethical question whether doctors should assist. I want now to look at some of the most important arguments for and against, beginning with the objections and then examining the counter-arguments[5].

(1) Physician assistance in suicide, some argue, is forbidden by medical ethics. Physicians should never be involved in causing death. The Hippocratic Oath

states 'I will neither give a deadly drug to anyone if asked, nor will I make a suggestion to this effect'. Some physicians and ethicists see a physician's assistance in suicide as morally equivalent to euthanasia. The counter-argument is that assisted suicide and active euthanasia sometimes look very similar, and sometimes do not. They look more similar in the Kevorkian-type 'assists' in which the physician provides a special machine, hooks the person up and supervises the procedures to assure the desired result. They look very different in cases where the physician provides information, or a prescription to a patient, as in the actions of Dr Timothy Quill[6]. Moreover, the prohibition against killing is not the only medical ethical norm, and arguably not the most important one in all situations.

(2) A second line of argument is based on the conviction that suicides among the terminally ill are a failure of the health professions and the humanity of society. The wish to kill oneself, some argue, stems from the fear of medical overtreatment, of being kept alive too long and against one's will. People turn to suicide because good palliative care is lacking and physicians are too aggressive with treatments. The answer to suicide assistance requests, then, should be more restraint and something like hospice care. This argument is powerful, if not finally compelling, because end-of-life care, at least in the USA, is too often devoid of proper palliation and emotional and spiritual support, not to mention being financially burdensome. A great deal needs to be done on this front. Yet this second line of argument is too simplistic and monolithic a response to a complex human predicament. Perhaps many requests from patients could be prevented by physician restraints and good hospice care, but many others would not.

(3) Third, and most troubling, there is the slippery slope objection and the idea that, if physician-assisted suicide becomes morally and legally permissible, it will inevitably lead to less discriminate acts involving voluntary and involuntary euthanasia. To contemplate physician involvement to any degree is to gaze into the moral abyss. Slippery slope arguments come in two forms, a logical argument and an empirical one. The logical argument says it is impossible to distinguish, morally, between physician-assisted suicide and active euthanasia, that they are in essence the same. There are no logical stops down the slope, no resting points that reason can find compelling. The empirical argument holds that logical distinctions are irrelevant; the issue is about what will happen, not how carefully doctors or legislators devising laws can reason. So even if slippery slope thinking is logical or fallacious, it may still be an accurate description of our practices. The world is, after all, not governed by logic. Physician assistance in suicide, which might be acceptable in a few cases, could unlink the safety net which restrains us from a more wholesale disregard for life to which our species is already prone.

The empirical side of the slippery slope is the one which gives me the most need to pause, yet it can be studied. On balance I feel that the benefits from changing policies to permit physician assistance in suicide in carefully specified cases outweigh the risks. The deficits of the current arrangements prohibiting physician assistance are substantial. Covert actions are more susceptible to abuse than overt ones, and hiding actions discourage communication among physicians, patients, families and colleagues. Such communication should be a formidable check on overstepping well-specified boundaries. Moreover, laws which prohibit any form of physician assistance enlarge the power physicians have over patients, but without enlarging the benevolent potential in the use of that power[7].

Conclusions

It is often said that physicians must seek the high moral ground. I agree with this but I worry that the high ground will simply be identified as continuing the moral injunction against assisting in death in any way, rather than a more realistic stance. The desire for a high ground, free of moral ambiguity, is likely to get us into trouble, because it will be out of touch with clinical realities and patient experiences. Montaigne said that if we seek ethical certainty we will fail, and that our too-lofty aspirations may blind us to the true nature of our practices.

> Two things I have always observed to be in singular accord supercelestial thoughts and subterranean conduct . . . there is no use our mounting on stilts, for on stilts we must still walk on our own legs. And on the loftiest throne in the world we are still sitting only on our own rump[8].

Fortune will not provide many of us with the quiet, dignified, inexpensive death at home that resides in our ideals. Some of us will be caught in situations in which we are overwhelmed not simply by a terminal illness, but by intractable suffering, severe disability, progressive dementia, loss of financial means and absence of a convivial order - friends, family and colleagues who can console us in our losses. Most horrifying, our dying can also burden our progeny, drastically altering their life prospects even after we are gone. Many of us might think this a fate worse than death by our own hand.

Though I cannot claim to have made the case, I believe one can be made for physician assistance; one that does not devalue the disabled or terminally ill, question the need for hospice, and weaken the traditional prohibition against killing. I note that the UK Institute of Medical Ethics Working Party Statement on Assisted Death generally agrees with this assessment[9]. In the effort to fomulate such a case, devise principles and assist in enacting laws, medical leadership would enhance the public trust in medicine. Physicians are inevitably involved in the management of death, the timing, style, and values involved in deciding how our lives will end. To be committed to only one vision about a good death is a too limited ethic, and medicine will embrace it at a cost in public confidence.

References

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2 Droge AJ, Tabor JD. *A Noble Death*. New York: Harper Collins, 1992

3 Thomas Aquinas. *Summa Theologica*, 2nd Part, 2nd Number, Question 64, Article 5

4 David Hume. In: Miller Eugene F, ed. *Essays Moral, Political and Literary*. Indianapolis: Liberty Classics, 1985

5 Weir Robert F. The morality of physician-assisted suicide. *Law Med Hlth Care* 1992;**20**:1-2, 116-26

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7 Quill Timothy E. *Death and Dignity: Making Choices and Taking Charge*. New York: W W Norton & Co., 1993:141

8 de Montaigne Michel. *The Complete Essays of Montaigne*, Frame Donald, Transl. Stanford: Stanford University Press, 1965:856

9 Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death. 'Assisted death' - a report. *Lancet* 1990;**336**:610-13